STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495245	A. BUILDING _____ B. WING _____	C 02/24/2017

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ARCADIA NURSING & REHAB CENT	17405 LANKFORD HIGHWAY NELSONIA, VA 23414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard survey was conducted 2/22/17 through 2/24/17. The facility was not in compliance with the following 42 CFR part 483 Federal Long Term Requirements. Two complaints were investigated during the survey. The Life Safety Code survey report will follow. The census in this 60 bed facility was 49 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1 through #14) and 1 closed record reviews (Resident #15).	F 000		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 167		4/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/16/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to display the past three years of survey results readily accessible to the Residents and public. The findings included: During the General Observation of the facility on 02/22/17 through 02/24/2017, the facility staff failed to display the three years of survey results readily accessible to residents and the public. A white binder titled "Facility Survey Finding Report" located in the front lobby on the counter contained the past two years of survey results. The surveyor asked the receptionist for the survey results for 2014, she replied, "I'm not sure where they are but I will find out for you". The receptionist made a phone call then stated, "I just spoke with the administrator; she will find them for you". On 02/23/17 at approximately 12:15 p.m., the administrator handed this surveyor the facility's survey results for October 2014. During an interview with the Administrator on 02/23/17, she replied, "I didn't realize three years of survey results needed to be displayed, I thought it was the past two years". On the same	F 167	• No resident was adversely affected by this deficient practice. The results of the most recent survey of the facility remain posted and available. The facility has posted a notice of the availability of such reports (all surveys during the preceding 3 years) in areas of the facility that are prominent and accessible to the public. • All residents that reside in a nursing facility have the potential to be affected by this deficient practice. • The facility Administrator was provided an in-service on ensuring the most recent survey remains available and posted and that a posted notice outlines availability of such reports (all surveys during the preceding 3 years) in areas of the facility that are prominent and accessible to the public • The receptionist will monitor the to ensure the most recent survey is available and posted and that all surveys for the preceding 3 years remain read and available upon request with required notice posted for 3 months to ensure on-going compliance. The facility policy on availability of survey results has been updated to reflect current regulation requirements.	

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F 167	Continued From page 2 day, at approximately 3:20 p.m., the Administrator handed this surveyor the facility policy for displaying of survey results. The facility Policy: "Examination of Survey Results" Revised on November 2016. The Policy Interpretation and Implementation: A copy of all survey, certifications, and complaint investigations made respecting the facility during the 3 proceeding years, along with any plan of correction (POC) in effect with respect to the facility, are maintained in a 3-ring binder located in an area frequented by most resident, such as the main lobby or resident activity room.	F 167	• The facility administrator will review to ensure the most recent annual survey availability, ensure the 3 preceding years of surveys are readily available should they be requested and required associated survey result notices are posted monthly for three months. Any adverse findings will be reported to the facility QAPI committee for action as indicated.	
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to assess for safe self administration of medication for 1 of 15 residents. (Resident # 7) Specifically, the facility staff failed to determine if Resident #7 could safely self administer nasal spray, deep sea .65 % (saline nasal spray). The findings included: Resident #7 was originally admitted to the facility	F 176	• Resident # 7 has suffered no adverse effects from not having an assessment and Physician's order for self administering of the nasal spray. On February 24,2017, resident # 7 was assessed for the ability to self administer his nasal spray, • All resident's that self administer medications have the potential to be affected by this deficient practice. • the licensed nursing staff will be provided inservice education on ensuring that self administering	4/6/17

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F 176	Continued From page 3 on 5/29/13 and re-admitted last on 5/5/16. Diagnoses for Resident # 7 included but are not limited to schizoaffective disorder depressive type, bi-polar with manic episodes, and unspecified psychosis. Resident #7's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/07/16 coded Resident #7 with impaired skills for daily decision-making to include unclear speech-slurred or mumbled words and difficulty communicating some words or finishing thoughts but is able if prompted or given time. In addition, Resident #7's behavior was coded with psychosis, delusions, verbal behaviors toward others, and rejection of care. The Minimum Data Set coded Resident #7 requiring limited assistance for Activities of Daily Living care. Resident #7 was coded 15 out of 15 on the Brief Interview for Mental Status indicating no cognitive impairment. Resident #7 was observed on 2/22/17 at approximately 7:10 a.m. with nasal spray on the bedside table with no staff in the resident's room. On 2/22/17, Resident #7's clinical record was reviewed. The reviewed showed a physician order dated and signed on 2/13/17. The order read Resident #7 was to get deep sea .65% saline nasal spray 4 times a day, one spray in each nostril for dryness. There were no orders or instructions regarding the self administration of medications. On 2/23/17 at 3:50 p.m. Resident #7 requested medications to be given prior to the scheduled smoke break at 4:00 p.m. LPN #2 was observed administering medications. LPN #2 placed the nasal spray on the table and watched Resident	F 176	of medication assessments are completed on all residents that wish to self administer medications and subsequent Physician orders have been obtained prior to allowing a resident to self-administer medication(s). The inservice will include that no medications are to be left with resident and/or at bedside without appropriate MD order. A 100% review of all residents that wish to self administer medications has been completed to ensure proper assessments and Physician orders have been obtained. The Unit manager nurse will review all residents that have order to to self administer medications monthly for 3 months to ensure that all assessments and orders are have been completed. • The Director of Nursing will review all residents with MD orders to self administer medications1 time per month for 3 months to ensure on going compliance. Any adverse findings will be reported to the facility QAPI committee for action as indicated.	

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#7 administer one spray to each nostril. Resident #7 was observed self-administering the nasal spray.

The care plan was reviewed for behaviors. On 12/26/16 Resident #7 had care planned interventions for the following behaviors: yelling, cursing, threatening others and referring to Satan. Resident #7 was not care planned to self-administer medications.

A nursing note dated 9/29/16, read that Resident #7 made an allegation that staff had, "a poison pill" and refused medication.

Several psychiatric progress notes were reviewed. There were no notes regarding assessments for self administration of medications.

No assessments were made to determine if Resident #7 was capable of self administering medications.

On 2/24/17 at approximately 6:30 a.m. RN #3 (Registered Nurse) was interviewed. RN #3 stated that he works regularly with Resident #7. RN #3 stated, "Two days ago I gave [the resident] 8:00 a.m. medications to include nasal spray." RN#3 added, "He won't let me stay in the room" and "I leave the nasal spray on the table and leave the room and walk away." RN #3 explained, "It's because of his behaviors, he will yell and tell me to get out". Finally, RN #3 stated, "Yes, I have seen him take the spray before but he insists that I don't watch and sometimes he won't allow it." No assessment for self-administration had been performed prior to the self administration of nasal spray on 2/22/17.

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F 176	Continued From page 5 On 2/24/17 at approximately 3:15 p.m. the Administrator and DON (Director of Nursing) were informed that Resident #7 self administered medication. The DON stated, "He [RN #3] should have watched resident take medications." The Administrator stated, "That's not suppose to happen (leaving medications with resident) if no order for self- administration the policy states: do not leave medications with patient" and "We follow the policy for Self-Administration of Medications." The Self-Administration of Medications policy with a revised date of 12/2012 documented : "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so." Also, "As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. The facility staff had no documentation a self- administration of medication evaluation or assessment for Resident #7. The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information about the findings .	F 176		
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing,	F 252		4/6/17

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F 252	Continued From page 6 as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure a safe, comfortable homelike environment for residents' shower room. The findings included: On 2/23/17 at approximately 4:15 p.m. an observation was made of the Residents' shower room. Several floor tiles were observed to be cracked and an area of concrete flooring at the entrance to the shower was observed to be cracked.	F 252	• No resident was adversely affected by this deficient practice. The blue shower chair was cleaned on February 24,2017 The shower room sink top was secured to the vanity on February 24,2017. The cracked tiles will be replaced by April 6, 2017. • All residents that use the shower room for bathing have the potential to be affected by this deficient practice. • The maintenance and housekeeping staff will be provided additional in-service education on ensuring that the facility maintains a clean, safe homelike environment to include the shower room	

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F 252	Continued From page 7 In addition, in the Residents' shower room, a blue shower chair was observed to have white substance on the back rest of the chair. The shower room sink top was also observed during this time to be loose from the wooden vanity. This was found when the surveyor rested hand down on top of the sink to wash hands and observed it to pull away from the wall and vanity below it. On 2/23/17 at approximately 4:15 p.m., the surveyor had to push hampers away to walk into the locked shower area. On 2/24/17 at approximately 10:30 a.m. the Maintenance Director stated that he would be able to rid the concrete areas of cracked tiles in the shower room tile floor by application of more concrete in the areas. The Maintenance Director stated that he was not aware of the loose sink top in the shower room. When asked for a Policy related to the Facility's cleanliness and equipment, the facility provided a Policy titled, "Grounds" from 2001 MED-PASS, Inc. (Revised August 2008. The Policy documented the following: "Facility grounds shall be maintained in a safe and attractive manner". An article from the website: http://nursinghomefamilies.com documented the following; The facility must provide - (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;	F 252	area. A 100% observation will be completed of the entire facility to ensure that the facility is maintained in a clean, safe, homelike environment for our residents. The Director of Housekeeping will observe the shower room to include the tiles, concrete, shower chairs and sinks 1 time a week for 3 months to ensure a clean, safe, homelike environment is maintained in this space. • The facility administrator will make facility rounds to ensure ongoing compliance one time a week for 3 months. Any adverse findings will be reported to the facility QAPI committee for action as indicated.	

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F 252	Continued From page 8 Environment refers to any environment in the facility that is frequented by residents, including but not limited to the residents ' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.	F 252		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 309		4/6/17

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F 309	Continued From page 9 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to reassess for pain after a verbal request 1 Resident (Resident #15) of 15 Residents in the survey sample. Resident #15 was no longer in the facility and investigated as a closed record. The findings included: Resident #15 was admitted to the facility on 1/6/17. Diagnoses for Resident #15 included but are not limited to hip fracture, Alzheimer's Disease and Anxiety Disorder. Resident #15's Admission Minimum Data Set (an	F 309	• Resident #15 suffered no ill effects from this deficient practice. Resident # 15 no longer resides at the facility. • Any resident that is at risk for pain is at risk from this deficient practice. • A 100% audit will be conducted of pain assessments of residents within the facility. Nursing staff was provided additional education on assessing residents for pain, to include non-verbal signs of pain and the documentation of the pain scale of these residents, with pain interventions up to and including ordered medications, given in a timely manner as well as follow-up with the resident. All residents will be assessed for pain at least once a shift and this will be recorded in the Medical Administration	

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F 309	Continued From page 10 assessment protocol-MDS) with an Assessment Reference Date of 1/13/17 coded Resident #15 a BIMS (Brief Interview for Mental Status) of 12 of 15, indicating a moderate cognitive impairment. In addition, Resident #15's Admission MDS coded her as requiring limited assistance with 1 staff person assistance for Dressing. Resident #15 was coded as being totally dependent with one staff person assistance for Toileting. Resident #15 was coded as having an ostomy for bowel functioning and was coded as always continent in urinary functioning. Resident #15's MDS coded her as activity did not occur for Transfers. Resident #15 was coded as requiring extensive assistance with one person physical assist for bed mobility. A Grievance Complaint form regarding Resident #15 dated 1/23/17 filed by the Social Worker #1 was made and it documented the following: Incident occurred: 1/22/17 at afternoon approximately 3:00 p.m. (NOTE: 1/22/17 is Sunday) Nature of Grievance: Resident #15's daughter was verbalizing concern related to her Mother's buttock pain. The Facility Social Worker called Resident #15's Responsible Party (daughter and complainant). The daughter visiting on 1/22/17 had spoken to the Charge Nurse Registered Nurse (RN) #4 twice and was told the pain was skin tags on Resident #15's buttocks. The Responsible Party (R/P) Daughter arrived at the facility after 3:00 p.m. and her mother was still in pain. The R/P asked RN #4 about her Mother's buttock pain and was told the pain was due to skin tags. The R/P prior to leaving for the	F 309	Record of each resident. The MDS nurse will assess 5 residents that are at risk for pain weekly for 8 weeks and review the documentation of the resident's pain scale documented in the MARs and compare that with the documentation of pain relief interventions up to and including ordered medication, and the documented follow-up after medication is given. • The Director of Nursing will review 3 residents who are at risk for pain weekly for 8 weeks to ensure ongoing compliance. Adverse finding will be reported to the Quality Assurance Committee.	

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evening again asked the RN #4 about her Mother's buttock pain and once again told the pain was due to skin tags.

The Grievance report documented: 1/23/17 Investigation is ongoing. The report also documented 1/27/17 Employee (RN #4) was terminated

The Grievance report documented: RN #4's statement. RN #4 RN #4 documented: ... (Resident #15's) daughter approached me to ask about treatment to (Resident #15's) buttocks. This was at 7 p.m. My mind was totally occupied with the missing narc and it took me a minute to respond. I responded calmly and asked her if it was about the skin tag on her buttock and she said not it was not that her buttocks had a red spot and was sore. She ten asked if we could put some A & D or something on it. I respond that the CNAs usually do that routinely. She then walked away and said ok that was good. She may have felt I brushed her off but that was not my intention."

The Grievance Report documented a statement from LPN (Licensed Practical Nurse) #4, who at 7:00 p.m. reported to work. LPN #4 reported not hearing all of the conversation, but did hear that (Resident #15's) daughter asked RN #4 how her mother's pressure sore was doing. LPN #4 stated that RN #4 responded: "Pressure Sore? What pressure sore? She doesn't have a pressure sore, it's a skin tag on her buttock. She don't have a wound back there."

The Physician 1/4/17 hospital Progress Note: documented: "Skin: greater than 5 inches area stage II appearance Decubitus on Sacral Glut

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area.
The National Pressure Ulcer Advisory Panel - NPUAP " Resources " Educational and Clinical Resources documents:
may indicate deep tissue pressure injury.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

The Nurse Practitioner's 1/23/17 1:00 p.m. documented the following:
Resident reports pain Left thigh, does not want to do therapy, "wishes God would take her and life here is purgatory"
2 new small pressure sore to sacrum
Assessment and Plan:
1. Status Post left hip femur repair with persistent pain...offered Fentanyl patch to adjunct pain pills
2. Depression-resident admits wanting to die...
3. Advanced Age...
4. Pressure sores-staff to start treatment, resident laying in bed a lot ...

Resident #15's Interim Plan Of Care (not dated) documented the following:

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Mobility: NWB (non weight bearing)
Toileting: Bedpan/by staff
Skin integrity: Preventative Care and Dressing Left Hip
Behavioral/Mental Status: Alert

Care Plan Interventions included: Reassurance and Position for comfort, 1/2 siderail for positioning

The Care Plan Problem dated 1/6/17 onset documented: At Risk for further skin breakdown related to Braden risk assessment score and decreased mobility due to fracture left femur. Admitted with stage II to right Buttocks.
Interventions included:
1/19/17 pressure reducing mattress to bed at all times
1/9/17 turn and reposition every 2 hours when in bed

The Care Plan Problem dated 1/6/17 Fractured Left Femur documented the following interventions:
Pain med per order
Document pain med effectiveness
Monitor pain, location, frequency duration, severity and document
Notify Medical Doctor of negative findings and or pain not relieved by current pain regimen

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Resident #15's 1/9/17 Braden Risk Assessment Report scored Risk as High Risk (12) for developing pressure ulcers. The 1/9/17 Braden Risk Assessment Report documented the

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following:
Mobility: Very limited - makes occasional slight changes in body extremity position but unable to make frequent or significant changes independently.
Nutrition: Probably Inadequate - Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement or receives less that optimum amount of liquid diet or tube feeding
Friction and Shear: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent reposition with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.

Resident #15's Weekly Skin Assessment of 1/15/17 and 1/22/17 documents the following:

Pressure Ulcer Right Buttock
Wound: Left hip surgical with sutures

1/6/17 1322 (1:22 p.m.) Admission Assessment and Care Plan documented the following note of LPN #4:
"...Small open area noted to Right buttocks. Family at bedside." Admission Assessment and Care Plan documented: "Right buttocks-very small open area - 0.2 centimeters (cm) by 0.2 cm.

Resident #15's Treatment Administration Record (TAR) documented the following Physician Orders:

1/6/17 Pressure reducing Mattress to bed at all

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times and was signed as having from 1/6/17 to 1/24/17.
1/6/17 Turn and reposition every 2 hours while in bed. and was signed as being done from 1/6/17 to 1/24/17.
1/6/17 Vitamin A & D to peri-area and buttock every shift and as needed and was signed as being done from 1/6/17 to 1/24/17.
1/11/17 Cleanse open area to buttocks with Dermal Wound Cleanser, pat dry, apply small amount wound gel and cover with foam dressing daily and as needed.

Resident #15's 1/9/17 Visual Body Map documented no pressure areas. The Visual Body map documented Bruise on buttock area, Left hip incision with 7 sutures to upper Left thigh and 4 sutures to Left lower thigh.

The 1/11/17 Admitting Evaluation and History note documented: Skin: bruising, hip incision, bed sore (no specifics on this note for bed sore)

Resident #15 on date of Grievance had the following medications ordered by the Physician:

1/17/17 Tramadol 50 mg (milligrams) and PO (by mouth) every 4 hours as needed for pain. The Medication Administration Record (MAR) documented none given on 1/22/17. Medline Plus documents: Tramadol is used to relieve moderate to moderately severe pain.

1/17/17 Acetaminophen 325 mg 2 tabs by mouth every 6 hours as needed for mild pain not to exceed 4 doses in 24 hours. The MAR documented none received on 1/22/17. Medline Plus documents: Acetaminophen is used to

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relieve mild to moderate pain.

A late entry nursing note dated 1/23/17 1630 (4:30 p.m.) (Administrator who is a LPN and the Director of Nursing (DON) "evaluated residents wounds to buttocks area. On right cheek there was a skin tag noted without redness, swelling or drainage noted. There were also noted to Left check about the size of a small pea. Resident did have addressing in place that was removed by (DON) Her attending nurse ... is aware."

On 2/22/17 at approximately 2:30 p.m. a phone interview was conducted with Resident #15's RP/daughter. The daughter stated her concerns for her Mother were: sores on her backside that hindered her ability to receive Physical Therapy. The RP stated she reported 4 times to the nurse about her Mother's pain in her back side. The RP stated the nurse did not reassess and kept saying the pain was because of a skin tag. The daughter also stated that Therapy had suggested an air mattress and none was provided. Other concerns from the daughter was that there was a sharp edge on the bed pan her Mother had to use. The RP stated that as no one would replace the bed pan, she threw in into the trash can. The daughter stated she had concerns also as to why the Nurse Practitioner would order a Fentanyl patch and an antidepressant after her examination. Medine Plus documents: Fentanyl is used to treat breakthrough pain (sudden episodes of pain that occur despite round the clock treatment with pain medications.

On 2/22/17 at approximately 4:40 p.m. an interview was conducted with the Facility Administrator who is also a LPN. The Administrator stated she learned of the

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daughter's complaint regarding Resident #15 on Monday 1/23/17. The Administrator stated she asked the Social Worker to follow up on the grievance. The Administrator stated that she and the DON observed Resident #15's bottom on 1/23/17. The Administrator stated that the RN #4 was terminated as she didn't assess Resident #15's reason for pain. The Administrator stated the RN did not re-look at the resident's bottom as she felt the pain was due to a skin tag she had seen previously. The Administrator also stated that the RN did not notify the Doctor due to unresolved pain.

On 2/22/17 at approximately 4:55 p.m., the Administrator stated that when she and the DON assessed Resident #15's buttock area on 1/23/17 that there two open non draining wounds on the Resident's Right Buttock. She stated she did not see evidence of any boils. The Administrator stated to her the areas looked to be caused by shearing.

On 2/24/17 at approximately 10:00 a.m. the Administrator wanted to clarify her statements regarding RN #4. The Administrator stated that on re-evaluation of her conversation with the Surveyor, she felt Resident #15 had been assessed and provided care. The Administrator stated she felt the issue was more related to the RN's lack of reassessing the Resident for her verbal complaints of pain and the family's reports of the Resident's pain.

The Facility Policy titled: "Pain Assessment and Management" from 2001 MED-PASS, Inc. (Revised March 2015) documented the following:

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F 309	Continued From page 18 Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Steps: Recognizing Pain, Assessing Pain, Identifying the Causes of Pain, Defining Goals and Appropriate Interventions, Implementing Pain Management Strategies, Monitoring and Modifying Approaches, and Documentation. The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.	F 309		
F 314 SS=D	COMPLAINT DEFICIENCY TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		4/6/17

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F 314	Continued From page 19 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews and review of the facility documentations, the facility failed ensure the necessary treatment was provided to prevent infection and promote healing for 1 of 14 Residents (Resident # 4) who entered the facility with pressure ulcers. The facility staff failed to ensure during wound care a standard to promote healing and prevent the spread of infection. The findings included: Resident #4 was admitted to the facility on 08/27/14. Diagnoses for Resident #4 included but are not limited to Nutritional Marasmus (1) and Kennedy sacral ulcer (2). Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/25/2017 coded Resident #4 for short-term and long-term memory problem with severely impaired for making decisions. In addition, the MDS coded Resident #4 requiring total dependence of one with bed mobility, dressing, eating, toilet use, personal hygiene and bathing of Activities of Daily Living care. Resident #4 was coded always incontinent of bowel, has indwelling Foley catheter to prevent urine from contaminating the sacral wound. The resident was observed lying in bed on an alternating low air loss mattress; positioned on her left side, Foley positioned properly draining clear yellow urine.	F 314	• Resident #4 suffered no adverse effects from this deficient practice. Resident # 4 now has their wound dressing changed according to facility policy and protocol in a manner to promote healing of the wound and to prevent the spread of infection. • All residents with wounds are at risk from this deficient practice. • Nursing staff will be provided addition education on the facility policy and protocol for the changing of wound dressing with emphasis on wound healing and prevention of the spread of infection. The Unit Manager will observe 3 dressing changes a week for 4 weeks for adherence to facility policy and protocol for dressing changes to promote healing and prevent the spread of infection. • The Director of Nursing will observe a dressing change once a week for 8 weeks to ensure ongoing compliance. Adverse findings will be reported to the Quality Assurance Committee.	

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In section "M" (Skin Conditions) of MDS 01/25/2017 coded Resident #4 at risk for developing pressure ulcer, but having a Stage 1 or higher pressure ulcer (3). Resident #4 was coded as having a stage 3 or 4 pressure ulcer (4) with the following measurements: 3.5cm x 4.4 cm with 0.4cm depth, wound bed with slough-yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

A Braden Risk Assessment Report was completed on 01/24/17; resident scored a nine indicating very high risk for the development of pressure ulcers. Mobility is completely immobile; does not make even slight change in body or extremity position without assistance.

According to the Treatment Administration Record (TAR) for January 2017, Resident #4 was started on Augmentin (5) 875 mg by mouth twice daily x 10 days starting on 01/26/2017 for sacral wound infection.

Resident #4's revised comprehensive care plan documented Resident #4 with actual skin breakdown to sacrum; a Kennedy ulcer, with further risk for impaired skin breakdown related to history of pressure ulcer, incontinence, decreased mobility and pressure ulcer risk assessment score. The goal: the resident will have no further pressure ulcer development. Some of the intervention/approaches to manage goal included Alternating Pressure Air Mattress (6), turn and reposition every two every hours, do not drag resident up in bed use lift sheet or pad to move, and check brief every two hours and change as needed (incontinent episodes).

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The current treatment as of 01/22/17 is to cleanse sacral wound with Dermal Wound Cleaner (7) (DWC) pat dry, apply Santyl (8) to base of wound, apply Calcium Alginate (aborsorbent wound dressing) and cover with foam dressing daily.

On 02/23/17 at approximately 11:00 a.m., Resident #4 was lying in bed, positioned on her left side lying on an alternating low air loss pressure mattress. LPN #3 performed wound care with the assistance of CNA #6. Prior to starting wound care to the Resident #4, LPN #3 used hand sanitizer but CNA #6 washed her hands for 20 seconds. The LPN positioned the resident on her right side with the assistance of CNA #6. LPN #3 used hand sanitizer and then donned a new pair of gloves. She then removed the Allevyn dressing (9) that covered the sacral wound and removed the sacral wound packing. A large amount of serosanquineous drainage ran down the resident's right buttocks; a clean 4x4 was used to wipe the wound drainage. The LPN then placed the soiled dressing inside a clear plastic bag in the resident's trash can.

The LPN removed her gloves, used hand sanitizer and donned another set of gloves. She then proceeded to spray the wound with DWC and wiped the wound using 4x4s then proceeded to pat the wound. The sacral wound had a yellow tissue wound bed, no odor present. After cleaning the sacral wound, the LPN applied a small amount of Santyl to the tip of a cotton Q-tip; LPN applied the Santyl to the yellow tissue; placed a 2cm x 2cm Alginate wound dressing

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over the wound then covered the sacral wound with a 12.9cm x 12.9cm Allevyn dressing.

An interview was conducted with LPN #3 on 02/23/17 at approximately 4:30.m. LPN #3 stated, "I only washed my hands once but I should have washed my hands at least three times, before I touched the resident, and especially after the removal of the old dressing and cleaning of the wound and again after the treatment was finished."

On 02/24/17 at 3:30 p.m., the wound care observation was discussed with the Administrator and the Director of Nursing (DON). The DON stated "The nurse should have washed her hands before the initial contact with the resident, after removing the soiled dressing and again after the competition of the dressing changes. Washing your hands prevents the spreading of germs/infections and prevents cross contamination from clean to dirty".

The facility's policy for Pressure Ulcer Treatment (Revised 2013)

"Purpose: The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers.
Steps in the Procedure to include but not limited to:

1. Clean beside stand. Establish a clean field.
2. Place the clean equipment on the clean field.
3. Tape a biohazard or plastic bag on the bedside stand or use a waste basket.
4. Adjust the height of the bed to waist level.
5. Position resident and adjust clothing to provide

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access to affect area.
6. Wash and dry your hands thoroughly.
7. Put on clean gloves. Loosen tape and remove soiled dressing.
8. Pull glove over dressing and discard into plastic or biohazard bag.
9. Wash and dry your hands thoroughly.
10. Open dry, clean dressing by pulling corners of the exterior wrapping, outward touching only the exterior surface.
11. Label tape or dressing with date, time and initials.
12. Using clean technique, open other products.
13. Wash and dry hands thoroughly.
14. Put on clean cloves.
15. Assess the wound and surrounding skin.
16. Cleanse the wound with ordered cleanser."

(1) Nutritional Marasmus is a condition of extreme malnutrition and emaciation; it is characterized by progressive wasting of subcutaneous tissue and muscle.

(2) Kennedy sacral ulcer is a specific type of bed sore (also referred to as pressure sore, pressure ulcer or decubitus ulcer) that is characterized by rapid onset and rapid tissue breakdown (http://www.bing.com/search?q=what+is+a+kennedy+ulcer&src=IE-SearchBox&FORM=IESR02).

(3) Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be

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affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

(4) Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

(4) Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

(5) Augmentin is used to treat certain infections caused by bacteria, including infections of the

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ears, lungs, sinus, skin, and urinary tract. Amoxicillin is in a class of medications called penicillin-like antibiotics. It works by stopping the growth of bacteria. Clavulanic acid is in a class of medications called beta-lactamase inhibitors. It works by preventing bacteria from destroying amoxicillin (https://medlineplus.gov/ency/article/007365.htm).

(6) Alternating low air loss pressure mattress is comprised of individual air cells that slowly inflate and deflate under the patient. The alternating or inflation/deflation of cells allow blood flow to reach all areas of the patient's body to heal and prevent bed sores (http://www.alternatingpressuremattress.com/whatisapp.html).

(7) DWC is an over-the-counter, non-toxic, non-irritating, no-rinse, first-aid antiseptic product (http://www.smith-nephew.com/professional/products/advanced-wound-management/dermal-wound-skin-wound-cleanser/).

(8) Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts).

(9) Allevyn Adhesive Hydrocellular Foam Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and

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F 314	Continued From page 26 promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foam-dressings-home.html).	F 314		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the course of a complaint investigation, the facility staff failed to ensure 5 of 5 puree diets were prepared and provided in a consistent texture.	F 371	• No resident was adversely affected by this deficient practice. Puree diets are now prepared at the correct consistency. • All residents that require a pureed diet have the potential to be affected by this	4/6/17

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F 371	Continued From page 27 The findings included: On 2/22/17 at approximately 11:30 a.m., an observation was made of tray line temperatures being taken for the lunch meal. The Puree diet meal consisted of: mashed potatoes, puree meat sauce and spaghetti and puree vegetable blend. When the puree diet foods were plated, it was observed the potatoes were a firm mound, the puree spaghetti and meat sauce when plated spread out into the bottom of the partitioned plate as did the puree vegetable blend. On 2/22/17 at approximately 11:45 a.m. the Dietary Aide #2 was asked how she prepared puree foods and how many puree diets were prepared. The Dietary Aide #2 stated there were 5 puree meals to prepare. The Dietary Aide #2 stated: "I blend it and add water depending on what it is. I make it like pudding or baby food." On 2/22/17 at approximately 11:50 a.m. Dietary Aide #2 and the Dietary Manager were asked if they were aware of a book with recipes for preparing foods to a puree state so that they are in a consistent texture. Both the Dietary Aide #2 and the Dietary Manager stated that they were not aware of a book with recipes to ensure puree food textures. On 2/23/17 at approximately 12:00 p.m. during an observation of the lunch meal, the Dietary Manager came into the dining room and asked if I had observed the puree food. One plate of puree food was observed and all textures were consistent. The Dietary Manager when asked if the Recipe Book was used today, she shook her head in a yes motion.	F 371	deficient practice. • The dietary staff will be provided additional in-service education on ensuring puree diets are prepared in a consistent texture. Education included information on the menu book related to preparing pureed foods and maintaining the proper consistency of the food items. The dietary manager will observe the pureed food items 1 time/day Monday through Friday for 4 weeks, then monthly for two months to ensure that the menu book is being used and that all pureed foods remain in compliance with the required consistency. • The facility administrator will randomly observe resident food trays 2 times per week for 4 weeks then monthly for two months to ensure on going compliance with the correct consistency of the pureed food items. Any adverse findings will be forwarded to the facility QAPI committee for action as indicated.	

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F 371	Continued From page 28 On 2/23/17 at approximately 2:30 p.m. the Administrator and the Dietary manager came to the surveyor. The Dietary Manager stated that they do have a book with recipes to ensure puree food texture. The Dietary Manager stated that the Dietary Aide #2 had the book on 2/22/17 for lunch meal preparation. On 2/24/17 at approximately 1:00 p.m. the Dietary Aide #2 was interviewed. The Dietary Aide #2 stated when asked if she actually followed the guidelines in the Recipe Book to ensure puree food texture. The Dietary Aide #2 stated there was no recipe for spaghetti. She stated she did not look for Pasta. When asked more specifically if the Dietary Aide #2 used the Recipe Book to ensure puree food consistency on 2/22/17 lunch meal preparation, the Dietary Aide stated: "No." The National Dysphagia (difficulty swallowing) Diet: Dysphagia Pureed website: www.swallowstudy.com/wp-content/uploads/2014 /05/National-Dysphagia documented the following: Rationale: The diet is designed for people who have moderate to severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information or Policies about the findings.	F 371		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h)	F 431		4/6/17

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The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature

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F 431	Continued From page 30 controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide direct observation of medication administration for 1 of 15 residents (Resident #7) and failed to store medications in locked compartment. 1. Specifically, the facility staff failed to observe Resident #7 self administer nasal spray, deep sea .65 % (saline nasal spray) on 2/22/17. 2. The facility staff failed to ensure medication was stored in a secured location, accessible to designated staff on The findings included: Resident #7 was originally admitted to the facility on 5/29/13 and re-admitted last on 5/5/16. Diagnoses for Resident #7 included but are not limited to schizoaffective disorder depressive type, bi-polar with manic episodes, and unspecified psychosis. Resident #7's Minimum Data Set (an assessment protocol) with an	F 431	• Resident # 7 suffered no adverse effects from this deficient practice. Resident # 7 now receives his ordered medication in accordance to facility policy for medication administration, to include the observation of the taking of the medication. Resident #l's medication is now securely stored in accordance to the facility policy for the storage of medication. • All residents receiving medications are at risk from this deficient practice. • Nursing staff received additional education on the administration of medication to include the observation of the residents taking their medications, as well as, the proper, secure storage of medications. The Unit Manager will observe a medication pass twice a week for 8 weeks to ensure nursing staff gives and stores medication according to facility policy. • The Director of Nursing will observe two medication passes a month for 2 months to ensure ongoing compliance.	

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F 431	Continued From page 31 Assessment Reference Date of 12/07/16 coded Resident #7 with impaired skills for daily decision-making to include unclear speech-slurred or mumbled words and difficulty communicating some words or finishing thoughts but is able if prompted or given time. In addition, Resident #7's behavior was coded with psychosis, delusions, verbal behaviors toward others, and rejection of care. The Minimum Data Set coded Resident #7 requiring limited assistance for Activities of Daily Living care. Resident #7 coded 15 on the Brief Interview for Mental Status indicating no cognitive impairment. Resident #7 was observed on 2/22/17 at approximately 7:10 a.m. with nasal spray on the bedside table with no staff in the resident's room. On 2/22/17, Resident #7's clinical record was reviewed. The reviewed showed a physician order dated and signed on 2/13/17. The order read, Resident #7 was to get deep sea .65% saline nasal spray 4 times a day, one spray in each nostril for dryness. There were no orders or instructions regarding the self administration of medications. The care plan was reviewed for behaviors. On 12/26/16 Resident #7 had care planned interventions for the following behaviors: yelling, cursing, threatening others and referring to Satan. Resident #7 was not care planned to self-administer medications. A nursing note dated 9/29/16, read that Resident #7 made an allegation that staff had, "a poison pill" and refused medication. Several psychiatric progress notes were	F 431	Adverse finding will be reported to the Quality Assurance Committee.	

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reviewed. There were no notes regarding assessments for self administration of medications.

No assessments were made to determine if Resident #7 was capable of self administering medications.

On 2/24/17 at approximately 6:30 a.m. RN #3 (Registered Nurse) was interviewed. RN #3 stated that he works regularly with Resident #7. RN #3 stated, "Two days ago I gave [the resident] 8:00 a.m. medications to include nasal spray." RN #3 added, "He won't let me stay in the room" and "I leave the nasal spray on the table and leave the room and walk away." RN #3 explained, "It's because of his behaviors, he will yell and tell me to get out". Finally, RN #3 stated, "Yes, I have seen him take the spray before but he insists that I don't watch and sometimes he won't allow it." No assessment for self-administration had been performed prior to the self administration of nasal spray on 2/22/17.

On 2/24/17 at approximately 3:15 p.m. the Administrator and DON (Director of Nursing) were informed that Resident #7 self administered medication with no observation from staff on 2/22/17. The DON stated, "He [RN #3] should have watched resident take medications." The Administrator stated, "We follow the policy for Self-Administration of Medications."

The Self-Administration of Medications policy with a revised date of 12/2012 documented : "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so." Also, "As part of their overall evaluation, the staff

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and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. The facility staff had no documentation a self- administration of medication evaluation or assessment for Resident #7. Resident #7 was not to take medication without a staff member present to observe and to administer it.

The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information about the findings .

2. The facility staff failed to ensure medication was stored in a secured location, accessible to designated staff only.

On 2/22/17 at approximately 9:10 a.m., the surveyor observed an open box of medication (*Spiriva HandiHaler 18mcg/capsule) sitting on top of the back hall medication cart unattended. The medication nurse, Registered Nurse (RN) #3 arrived to the medication cart at approximately 9:20 a.m. The surveyor asked RN #3, if he was aware an open box of Spiriva was sitting on top of his medication cart unattended, he replied, "Yes, I usually leave the box of Spiriva on top of the medication cart as a reminder to myself to go back and make sure Resident #7 has taken his medications". RN #3 also stated, "Resident #7 requested to have his medication left on his bedside table; he will take them when he's ready". The surveyor asked RN#3 should the Spiriva had been left on top of his medication cart or locked inside the medication cart; he replied "Locked

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inside the cart". He then removed the Spiriva HandiHaler 18mcg/capsules from the top of the medication cart and locked it inside the medication cart.

*Spiriva HandiHaler is used to prevent wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to air sacs in the lungs). Spiriva in a class of medications called *bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier (https://medlineplus.gov/ency/article/007365.htm).

*Bronchodilators are inhaled medicines that help open up the airways. They are used to treat asthma and chronic bronchitis. Adrenergic bronchodilator overdose occurs when someone accidentally or intentionally takes more than the normal or recommended amount of this medicine. This can be by accident or on purpose (https://medlineplus.gov/ency/article/007365.htm).

On 02/22/17 at approximately 1:15 pm., the Unit Manager (UM - LPN #1) was made aware that RN #3 had left an open box of Spiriva HandiHaler 18 mcg/capsules unattended sitting on top of the medication cart.

The above information was shared with the Administrator and Director of Nursing (DON) during a pre-exit meeting on 2/24/17 at 3:30 p.m. No additional information was provided.

The facility's policy: Storage of Medications -

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F 431	Continued From page 35 (Revised April 2007) The facility's Policy Statement: "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner." The facility's Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.	F 431		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		4/6/17

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F 441	Continued From page 36 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective	F 441		

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F 441	Continued From page 37 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews and review of the facility documentation the facility staff failed to maintain an infection control program to provide a safe, sanitary environment to prevent the development and transmission of disease and infection for 1 of 14 residents (Resident #4) in the survey sample. The facility staff failed to dispose of heavily soiled dressings into a Biohazard container for disposal after the completion of a sacral wound dressing and failed to wash her hands according to standards of practice during wound care. The findings included: Resident #4 was admitted to the facility on 08/27/14. Diagnoses for Resident #4 included but are not limited to Nutritional Marasmus (1) and Kennedy sacral ulcer (2). In section "M" (Skin Conditions) of MDS 01/25/2017 coded Resident #4 at risk for developing pressure ulcer, but having a Stage 1 or higher pressure ulcer (3). Resident #4 was coded as having a stage 3 or 4 pressure ulcer (4) with the following measurements: 3.5cm x 4.4 cm with 0.4cm depth, wound bed with slough-yellow	F 441	• Resident # 4 suffered no adverse effects from this deficient practice. CNA # 6 and LPN # 3 were provided additional in-service education on proper hand washing and proper disposal of heavily soiled dressing changes. • All residents have the potential to be affected by this deficient practice. • Licensed Nurses and CNAs will be provided additional in-service education on infection control, to include proper hand washing techniques and proper disposal of heavily soiled dressing changes. The Unit Manager will observe 3 dressing changes per week for 4weeks to include a 1 time a week review of resident # 4 to ensure proper hand washing and disposal of heavily soiled dressing changes are disposed of per policy, then monthly for two months. . • The Director of nursing will randomly observe 1 dressing change per week for 8 weeks to ensure ongoing compliance. Any adverse findings will be reported to the facility QAPI committee for action as indicated.	

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or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

Resident #4 revised comprehensive care plan documented Resident #4 with actual skin breakdown to sacrum Kennedy ulcer with further risk for impaired skin breakdown related to history of pressure ulcer, incontinence, decreased mobility and pressure ulcer risk assessment score. The goal: the resident will have no further pressure ulcer development. Some of the intervention/approaches to manage goal included Alternating Pressure Air Mattress (5), turn and reposition every two every hours, do not drag resident up in bed use lift sheet or pad to move, and check brief every two hours and change as needed (incontinent episodes).

The current treatment as of 01/22/17 is to cleanse sacral wound with Dermal Wound Cleaner (6) (DWC) pat dry, apply Santyl (7) to base of wound, apply Calcium Alginate (absorbent woound dressing) and cover with foam dressing daily.

On 02/23/17 at approximately 11:00 a.m., Resident was lying in bed, positioned on her left side lying on an alternating low air loss pressure mattress. LPN #3 performed wound care with the assistance of CNA #6. Prior to starting wound care to the Resident #4, LPN #3 used hand sanitizer but CNA #6 washed her hands x 20 seconds. The LPN positioned the resident on her right side with the assistance of CNA #6. LPN #3 used hand sanitizer and then donned a new pair of gloves. She then removed the Allevyn

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dressing (8) that covered the sacral wound and removed the sacral wound packing. A large amount of serosanquineous drainage ran down the resident's right buttocks; a clean 4x4 was used to wipe the wound drainage. The LPN then placed the soiled dressing inside a clear plastic bag in the resident's trash can.

The LPN removed her gloves, used hand sanitizer and donned another set of gloves. She then proceeded to spray the wound with DWC and wiped the wound using 4x4s then proceeded to pat the wound. The sacral wound had a yellow tissue wound bed, no odor present. After cleaning of the sacral wound, the LPN applied a small amount of Santyl to tip of a cotton Q-tip; LPN applied the Santy to the yellow tissue; placed a 2cm x 2cm Alginate wound dressing over the wound then covered the sacral wound with a 12.9cm x 12.9cm Allevyn dressing. After LPN and CNA completed Resident #4 dressing change, CNA washed her hands x 20 seconds and the nurse washed her hands x 30 seconds. The CNA removed the clear plastic trash bag from the resident's trash can that contained the heavily soiled dressing, tied the bag up, walked out of the room then put in a large black barrel located in the hallway.

An interview was conducted with CNA #6 on 02/23/17 at approximately 3:00 p.m. The surveyor asked the CNA, "Where did you put the clear trash bag that contained the soiled dressing from the wound care of Resident #4", she replied, "I can't tell a lie, I put it in the black trash container in the hallway, I should have put it in the Biohazard red box in the trash room".

An interview was conducted with LPN #3 on

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02/23/17 at approximately 4:30 p.m. This surveyor asked LPN #4 if she knew where the CNA put the trash bag with the heavily soiled dressing from the wound care, she replied "Yes, in the trash can in the hall." This surveyor asked LPN #4 "Is that where heavily soiled dressing usually go" she replied, "The soiled dressing should have gone in a red bag then placed in the Biohazard room". The LPN #3 also stated, "I only washed my hands once but I should have washed my hands at least three times, before I touched the resident, and especially after the removal of the old dressing and cleaning of the wound and again after the treatment was finished".

On 02/24/17 at 3:30 p.m., the Administrator and the Director of Nursing (DON) informed that the soiled dressing from Resident #4 dressing change went into a clear plastic bag then put into the regular trash in the hallway. The DON stated "The dressing should have gone into a red bag and put into the Biohazard box". The DON also stated "The nurse should have washed her hands before the initial contact with the resident, after removing the soiled dressing and again after the competition of the dressing changes. Washing your hands prevents the spreading of germs/infections and prevents cross contamination from clean to dirty".

The facility's policy for Dressings, Soiled/Contaminated (Revised August 2009)

The facility's Policy Statement:
All-soiled/contaminated dressing must be handled in a safe and sanitary manner and must be incinerated or disposed of following decontamination or containment.

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The facility's Policy Interpretation and Implementation:
3. Soiled dressings that are heavily soiled with exudate or drainage or from a resident with an infectious condition must be placed in specially designated "BIOHAZARD" containers for disposal.

The facility's policy for Handwashing/Hand Hygiene: (Revised August 2015)

The facility's Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infection.

The facility's Policy Interpretation and Implementation:
2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.
7. B. Before and after direct contact with residents;
G. Before handling clean or soiled dressings, gauze pads, etc.;
J. After contact with bloody bodily fluids:

(1) Nutritional Marasmus is a condition of extreme malnutrition and emaciation; it is characterized by progressive wasting of subcutaneous tissue and muscle.

(2) Kennedy sacral ulcer is a specific type of bed sore (also referred to as pressure sore, pressure ulcer or decubitus ulcer) that is characterized by rapid onset and rapid tissue breakdown (http://www.bing.com/search?q=what+is+a+kennedy+ulcer&src=IE-SearchBox&FORM=IESR02).

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(3) Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages).

(4) Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages).

(4) Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is

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F 441	Continued From page 43 an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). (5) Alternating low air loss pressure mattress is comprised of individual air cells that slowly inflate and deflate under the patient. The alternating or inflation / deflation of cells allow blood flow to reach all areas of the patient's body to heal and prevent bed sores (http://www.alternatingpressuremattress.com/whatisapp.html). 6) DWC is an over-the-counter, non-toxic, non-irritating, no-rinse, first-aid antiseptic product (http://www.smith-nephew.com/professional/products/advanced-wound-management/dermal-wound-skin-wound-cleanser). (7) Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts). (8) Allevyn Adhesive Hydrocellular Foam Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foa	F 441		
F 465	SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		4/6/17

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F 465 SS=F	Continued From page 44 E ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure a sanitary environment. The Findings Included: On 2/22/17 at approximately 7:15 a.m., observations were made of trash cans just outside of the main kitchen. Three trash can lids were not secured. One of the trash cans was observed to be over filled not allowing the lid to be secured. The other two trash can lids were not secured; however, the cans were not over filled with trash. The Dietary Manager stated that the Housekeeping Department was responsible for managing and securing the trash cans. Review of the Facility's Policy titled: "Grounds" from 2001 MED-PASS, Inc. (Revised August	F 465	• No resident suffered any adverse effects from this deficient practice. The 3 trash can lids were secured on 2/22/17. • All residents that resident in a nursing facility have the potential to be affected by this deficient practice. • The 3 trash can lids were secured on 2/22/17. The housekeeping staff will be provided additional in-service education on ensuring a safe/functional/sanitary/ Comfortable environment to include outside trash receptacles and secured lids. The housekeeping supervisor will monitor outside trash receptacles 2 times per week for 6 weeks while conducting facility rounds to ensure that all lids are secure on trash receptacles. • The facility administrator will randomly observe outside trash receptacles 2 times per week for 6 weeks to ensure ongoing compliance with the securing of trash can lids. Any adverse findings will be reported to the facility QAPI committee for action	

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F 465	Continued From page 45 2008) documented the following: Facility grounds shall be maintained in a safe and attractive manner. The CDC (Center for Disease Control) documents that environmental management practices of trash storage is important to reduce infection by precautions of controlling pests, rodents, and other vectors. The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information or Policies about the findings.	F 465	as indicated.	
F 468 SS=D	CORRIDORS HAVE FIRMLY SECURED HANDRAILS CFR(s): 483.90(i)(3) (i)(3) Equip corridors with firmly secured handrails on each side; and This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the course of a complaint investigation, the facility staff failed to ensure all handrails were safely secured. On 2/23/17 at approximately 4:45 p.m., a loose handrail was observed on the wall between the Administrative Offices and the bathrooms. In addition, a loose handrail was observed 2/23/17 at approximately 4:50 p.m. to the right side of Room 102's door. On 2/24/17 at approximately 10:30 a.m. on tour of facility with the Maintenance Director, the hand	F 468	• No resident suffered any adverse effects from this deficient practice. The handrail located between the Administrative offices and the bathrooms as well as the handrail located to the right side of room 102's door have been repaired. • All residents have the potential to be affected by this deficient practice. • The handrails between the Administrative offices and the bathroom as well as the handrail located to the right of room 102's door have been repaired and are now secure. A 100% observation	4/6/17

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F 468	Continued From page 46 rail by the Administrative offices was observed again to be loose from the wall. In, addition, it was observed the handrail to the right of room 102's door had already been repaired. The Maintenance Director stated that he would fix the remaining unsecured handrail. The facility administration was informed of the findings during a briefing on 2/24/17 at approximately 3:30 p.m. The facility did not present any further information or Policies about the findings.	F 468	has been conducted to ensure that all handrails throughout the facility are secure. The facility staff as well as the Director of maintenance will be provided additional in-service education on ensuring that handrails are secure and pose no safety issues. The Director of maintenance will observe all handrails monthly during the monthly safety review to ensure all handrails are secured. • The facility administrator will observe all facility handrails 1 time per month for 6 months to ensure ongoing compliance with secured handrails. Any adverse findings will be reported to the facility QAPI committee for action as indicated.	